Charles County Government
Affidavit for each eligible dependent child age 19 to 26

Employee Name:_____ Social Security Number: _____
(Please print clearly)

If you are eligible to participate in the Charles County Health and Dental Plan, your child will be eligible for medical and dental coverage under the Plan if he or she is under age 26, regardless of whether the child is married, is a student or is dependent on you for support. **However, your child will not be eligible for coverage under the Plan for any period when the child is eligible for other employer-sponsored medical coverage** (other than coverage under another plan of any parent).

Dependent Name: _____ Social Security Number: _____

Dependent's Date of Birth: ___/___/___ Is your dependent currently employed? _____ Yes _____ No

Is your dependent eligible for his/her own employer-sponsored health coverage? _____ Yes _____ No

Is your dependent married? _____ Yes _____ No If yes, is your child eligible for health coverage through his/her spouse's employer-sponsored health plan? _____ Yes _____ No

By signing below, I certify that the child named above is not enrolled in and is not eligible to enroll in any employer-sponsored coverage based on the child's employment or their spouse's employment or under any other plan other than a plan of a parent of the child. If the child I am enrolling in the Plan becomes eligible for coverage under another plan (other than a parent's plan) in the future while the child is enrolled in this Plan's medical and/or dental coverage, I understand that I am required to inform the Department of Human Resources of that eligibility as soon as practicable. I understand and agree that failure to timely notify the Charles County Government of a change in the child's eligibility for their employer's healthcare coverage (or spouse's), as set forth in this Affidavit, may result in the denial of healthcare claims under the County's healthcare plan or pursuit by the County for reimbursement for benefits inappropriately received. I understand the County may verify my child's continued eligibility by requesting appropriate documentation. If I do not respond to these requests, my child's coverage may be terminated.

I hereby certify under the penalties of perjury that the contents of the foregoing affidavit are true and correct to the best of my knowledge, information and belief.

Signature of Employee: _____ Date: _____